SECTION 7
BENEFITS & LIMITATIONS

Office Visit Limitations

An office visit includes, but is not limited to, the following:

- Oral examination of the patient for symptoms or indications of a dental condition requiring treatment;
- Establishment of the written patient record;
- Surgical gloves, drapes, tongue depressors, swabs, gauze, medications, administration of injection(s) and any other items or supplies considered to be routine to the dentist's private practice; and
- Local anesthesia.

Office visits are limited to one visit per patient per provider on any given day and may not be billed on the same date of service as another office or outpatient visit, dental screen, subsequent hospital visit, consultation or nursing home visit. An office visit may be billed on the same date of service as a hospital admission.

Procedure codes 99201-99332 cannot be billed on the same date of service as procedure codes D0120-D0170 and D9310-D9440.

"New Patient" office visits are limited to one per provider for each patient when dental services have not been received in the past two years.

Billing for an office visit is expected *only* for the first session in a series of treatments.

Providers cannot bill a patient for missed/broken appointments, nor can the Division of Medical Services (DMS) reimburse providers for missed/broken appointments.

Preventative

Prophylaxis of either the upper or lower arch or both arches is covered once in a six-month period. ***If a prophylaxis is required more often than every six months, a provider may bill under procedure code D9999 and attach office notes to the claim form explaining the medical necessity***. Prophylaxis must include scaling and polishing of teeth unless scaling is not required for the individual (usually a child) based on the condition at the time of the appointment. The patient's record must document scaling was not required during the visit.

D1110 – Ages 13-125
D1120 – Ages 0-12

Fluoride treatment is limited to one application of stannous fluoride or acid-phosphate fluoride in six-month intervals. Each allowable fluoride treatment must include both the upper and lower arch. Fluoride treatments are covered for patients under the age of 21.

D1201 – Includes the prophylaxis
D1203 – Prophylaxis not included

Fluoride treatments for patients 21 and over (D1204) are limited to the following criteria:

- Patients with rampant or severe caries (decay);
- Patients who are undergoing radiation therapy to the head and neck;
- Patients with diminished salivary flow;
- Mentally retarded individuals who cannot perform their own hygiene maintenance; or
- Patients with cemental or root surface caries secondary to gingival recession.

Sodium fluoride series treatments are *not* covered.

Dental sealants are covered for patients age 5 through 20, with the exception of patients with ME code 76. Sealants may be applied only on healthy first and second permanent molars which have not had the occlusal surface restored. Valid tooth numbers are 2, 3, 14, 15, 18, 19, 30 and 31. Payment for each tooth is a once in a lifetime fee. No payment is made for sealants applied to third molars.

Periodontal Scaling and Root Planing – D4341

Procedure code D4341 requires an approved prior authorization (PA). Along with the PA request, providers must submit a pretreatment x-ray (a full mouth survey taken within the last 12 months) and a periodontal chart. The following guidelines are used to determine medical necessity for approval of the PA request. Approval, if given, is per quadrant:

- Verifiable signs of early or moderate chronic periodontia;
- Records must show two or more sites in the quadrant being treated with;
    1) probing depths of 5mm or greater; ***and***
    2) early to moderate bone loss, ***or***
    3) radiographic evidence of subginvgival calculus.

Definition of bone loss:

- Early bone loss is cratering, or horizontal or vertical loss.
- Moderate bone loss is notable bone loss with 50% of the root remaining in the bone.

Restorations

- The same restoration on the same tooth in less than a six-month period is not allowed.
- Amalgam restorations include polishing, local anesthesia, liner and treatment base.
- Resin restorations include local anesthesia, liner and treatment base.
- When billing for any of the amalgam, composite or resin restorations, the tooth number and tooth surface code(s) must be entered on the claim.
- Amalgam and resin restorations on posterior teeth are covered; resin restorations are covered on *anterior* teeth.

Crowns

- Prefabricated stainless steel crowns (D2930 and D2931) and prefabricated stainless steel crowns with resin window (D2933) for primary and permanent teeth are covered for patients of all ages; replacement within six months is not covered.
- Prefabricated resin crowns are covered for patients of all ages for *anterior* teeth only; replacement within six months is not covered.
- The fee for fixed prefabricated crown of chrome, stainless steel, resin, stainless steel with resin window or polycarbonate includes all prior preparations.
- Temporary crowns, D2970, are covered for patients under the age of 21.
- Porcelain crowns are covered for patients under the age of 21 on a prior authorized basis.

Extractions

- Procedure code D7140 is the appropriate code for all non-surgical extractions of erupted teeth, permanent and primary. The appropriate tooth number must be shown on the claim.
- Surgical removal of erupted teeth, D7210, is covered for permanent teeth only.
- The surgical removal of impacted teeth, D7220-D7241, is a covered service. A paper claim must be submitted for the removal of impacted teeth other than third molars and must include pre-treatment x-rays.
- The surgical removal of residual tooth roots (cutting procedure), D2750, is covered but cannot be billed on the same date of service as an extraction of the same tooth. Pre-treatment x-rays and office notes or operative report must be sent with the claim.
- Extraction fees for routine and impacted teeth include the fee for local anesthesia and post-operative treatment.

Please refer to Section 13 of the Medicaid *Dental Provider's Manual* and the Dental Appendix for comprehensive coverage of dental benefits and limitations, as well as covered procedure codes, available on the Internet at www.dss.mo.gov/dms.